Vernon Sleep Clinic

R. Cridland M.D. Inc

Patient Referral Requisition

Patient Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

_____ **Email:** _____

DOB: d/m/yr _____ **PHN#:** _____

Sex: Male ☐ Female ☐ Other ☐

Referring Physician: _____ **Phone:** _____

Address: _____

_____ **Billing #:** _____

Type of referral:

☐ Sleep Disorders Consultation with Polysomnogram as indicated

☐ Level III Cardiorespiratory Study – **sleep apnea screening only**, with Auto-CPAP trial if indicated

Reason for referral:

☐ Sleep Apnea	☐ Restless Legs Syndrome	☐ Chronic Fatigue/Fibromyalgia
☐ Excessive Daytime Sleepiness	☐ Periodic Limb Movements	☐ Seasonal Affective Disorder
☐ Narcolepsy	☐ Parasomnia (eg: sleepwalking)	☐ Other (please specify)
☐ Chronic Insomnia	☐ Shift-work related problem	_____

Relevant History: _____

_____

_____

Is this referral for disability or medico-legal purposes? ☐ Yes ☐ No

If this referral is URGENT, please explain: _____

Additional Comments or concerns: _____

- Please fax to: **(250) 541-0550**, or mail to: **304-2520 53rd Ave, Vernon, BC V1T 9W8.**
- For referral purposes, Dr. Cridland's MSP billing # is: 26582.

PLEASE ENCLOSE copy of CBC, TSH, Oximetry or Sleep Study reports if available to prevent duplication.

We will contact the patient directly to book the appointment. Thank you for your referral.

Physician Signature:_____ **Date:** _____